Ohio | Department of Job and Family Services

Mike DeWine, Governor
Kimberly Hall, Director

October 8, 2019

Lora S. Fuller, Executive Director
Scioto County Children Services
3940 Gallia Street
New Boston, OH 45662

Re: Child Fatality Administrative Case Review Final Report

Dear Director Fuller:

The Ohio Department of Job and Family Services (ODJFS), Office of Families and Children (OFC), Bureau for Systems and Practice Advancement (BSPA), completed a Child Fatality Administrative Case Review for case #55393994. The period under review was January 11, 2019 through June 24, 2019.

As a result of the discussion during the exit conference with Scioto County Children Services on September 16, 2019, ODJFS updated the final child fatality review report to change references of "meconium" to "umbilical cord." Additionally, ODJFS included language to indicate that Scioto County Children Services became aware of the child's death via media on June 12, 2019. Finally, ODJFS revised recommendation #4 to indicate the need for the agency to make case decisions based on a holistic and individualized assessment of the family's circumstances "and assure that the decision-making factors are documented in the case file." Enclosed is a copy of the final report.

Based on the findings of the review, Scioto County Children Services was found to be out of compliance with the Ohio Administrative Code. Given the serious nature of the findings and the factors contributing to non-compliance, Scioto County Children Services will be required to submit a Corrective Action Plan (CAP) detailing the steps the agency will take to improve upon practice.

Within thirty (30) days of receipt of this report, Scioto County Children Services must develop and submit a written Corrective Action Plan to Gina Speaks-Eshler, Bureau Chief, ODJFS, OFC, BSPA, P.O. Box 183204, Columbus, Ohio 43218-3204 or e-mail at Gina.Speaks-Eshler@jfs.ohio.gov.

In addition, because of ODJFS' recent findings detailed in the final report and concerns highlighted by Scioto County Children Services in the response received dated September 27, 2019, ODJFS would like to offer the following support which can be incorporated into Scioto County Children Services' CAP:

1. Place a technical assistance team member on-site in Scioto County on a weekly basis.

This team member will:

a. Serve as a technical assistance resource;
b. Provide on-site CAPMIS Infusion training to enhance overall agency practice;
c. Provide oversight and direction as to appropriate next steps for cases that escalate; and
d. Conduct ongoing case reviews.

2. Engage Scioto County as a case study/pilot to inform and identify strategies for sustainable children services transformation.

Please let me know by Tuesday, October 15, 2019 if Scioto County Children Services would like to capitalize on the above additional support and resources, or if there are any questions regarding the final report.

This report contains confidential information and should not be released outside of the county or ODJFS without completing the necessary redactions. ODJFS will not be responsible for any unauthorized release of confidential information that may occur as a result of ODJFS providing this report to the county.

Thank you for your cooperation in this important matter. If you have any questions, or would like assistance developing your CAP, please contact Lynn Boose, Technical Assistance Specialist at (937) 264-5746 or email Lynn.Boose@jfs.ohio.gov.

Sincerely,

Carla K. Carpenter
Deputy Director, Office of Families and Children
Ohio Department of Job and Family Services

cc: Gina Speaks-Eshler, OFC
Gina Velotta, OFC
Lynn Boose, OFC
File Administrative

Ohio Department of Job and Family Services
Office of Families and Children
Child Fatality Administrative Review
Final Report

NOTICE: CONFIDENTIAL INFORMATION IS CONTAINED THROUGHOUT THIS REPORT. In accordance with sections 2151.421, 5101.13 through 5101.134 and 5153.17 of the Ohio Revised Code and section 5101:2-33-21 and 5101:2-33-23 of the Ohio Administrative Code, unauthorized dissemination or re-release of such confidential information is prohibited and may be punishable as a misdemeanor in the fourth degree.

Purpose of the Review

The Ohio Department of Job and Family Services (ODJFS) conducted an administrative review on the [redacted] case as a result of circumstances surrounding the death of [redacted] The purpose of the administrative review was to review compliance with Ohio Revised Code (ORC) and Ohio Administrative Code (OAC) and to assess casework practice and service provision.

A review of the case using the Child Protection Oversight and Evaluation (CPOE) Stage 11 review tool[1] was conducted by Technical Assistance Specialists Lynn Boose and Melissa Potteiger. The period under review (PUR) was January 11, 2019 through June 24, 2019. The case review process was comprised of an examination of both the Statewide Automated Child Welfare Information System (SACWIS) and hard copy records as well as interviews with casework and supervisory staff assigned to the case during the period under review as well as the target child's foster parent.

Child Fatality Administrative Review Details

Case Name: [redacted]

Agency Name: Scioto County Children Services (SCCS)

Date of Fatality: Unknown. SCCS was notified of the child fatality on June 12, 2019

ODJFS Notification: June 14, 2019

Assigned for Preliminary Review: June 14, 2019

Child Fatality Review Committee Recommendation: June 17, 2019

County Notified of Administrative Review: June 21, 2019

Entrance Conference Held: June 24, 2019

[1] Child Protection Oversight and Evaluation (CPOE) is Ohio's continuous quality improvement framework for statewide case reviews. For CPOE Stage 11, Ohio has utilized the federal Child and Family Services Review Round 3 case review instrument.

Reconciliation of Findings: July 1, 2019

Exit Conference Held: September 16, 2019

Written Response Received from Agency: September 30, 2019

Final Report Issued: October 8, 2019

Identifying Information/Case Participants

Name	Role	DOB	Age	Race	Ethnicity	Living Arrangement
[redacted]	Target Child	[redacted]	< 1	White	Non-Hispanic	Non-Relative Foster Home [redacted]
[redacted]	Sibling	[redacted]	[redacted]	White	Non-Hispanic	[redacted]
[redacted]	Biological Mother					
[redacted]	Biological Father					
[redacted]	Foster Mother					Foster Mother of Target Child [redacted]
[redacted]	Aunt, Foster Mother					Aunt, Relative Foster Mother of Sibling [redacted]
[redacted]	Uncle, Foster Father					Uncle, Relative Foster Father of Sibling [redacted]

Documents Reviewed

- The SACWIS case record.
- The hard copy file.

Parties Interviewed

- Lauren Johnson, Intake Caseworker [redacted]
- Megan Hankins, Intake Caseworker [redacted]
- Kelli Burgess Potts, Intake Supervisor
- Patricia Craft, Ongoing Caseworker [redacted]
- Lisa Thomas, Ongoing Supervisor
- Dr. Lorra Fuller, Executive Director
- [redacted] Foster Mother of Target Child

Case Summary

Scioto County Children Services (SCCS) became involved with the family on [redacted]

The next section of the report will detail the reviewers' evaluation of each of Scioto County Children Services interventions with the target child's family. As previously noted, the reviewers utilized the Child Protection Oversight and Evaluation (CPOE) Stage 11 review tool to assess casework practice and service provision.

CASE REVIEW & DISCUSSION

I. SAFETY

Timeliness of Initiating Investigations

Traditional response investigations shall be initiated within 24 hours of the screening decision, and face-to-face contact with all ACVs shall be attempted within the first 72 hours of the screening decision, in accordance Ohio Administrative Code (OAC) rule 5101:2-36-03 *PCSA Requirements for Intra-Familial Child Abuse and/or Neglect Assessment/Investigations.* [redacted]. The report was initiated within 24 hours on [redacted] by face-to-face contact with the target child, the mother, and the father. Face-to-face contact with the sibling was not attempted within the first 72 hours of the screening decision but was completed on [redacted]

[redacted] The report was initiated within 24 hours on [redacted] by attempted face-to-face contact with the target child, the mother, and the father. Per OAC rule 5101:2-36-03, if the initial face-to-face contact was not successful, then a second attempt is required within the first four working days and at least every five working days thereafter until face-to-face contact is completed. A second attempt at face-to-face contact with the ACV occurred within the first four working days on [redacted] in accordance with rule. Ongoing attempts at face-to-face contact with the ACV occurred on [redacted] however, the frequency of attempts at face-to-face contact with the target child did not occur at least every five working days for two of the four attempts.

[redacted]

Timeliness of initiation and face-to-face contact with the ACV were not applicable due to the

fatality and the incarceration and criminal investigation of both parents related to the target child's death. At the time of this review, the agency was unable to contact the parents or notify them of [redacted] allegations against them.

Technical Assistance

SCCS is reminded to attempt face-to-face contact with all children listed as an ACV on an intake report within 72 hours following the screening decision. Furthermore, when face-to-face contact is not made with an ACV within 72 hours, the agency is required to make ongoing attempts at face-to-face contact with the ACV at least every five working days until the child is seen or until the agency is required to make a report disposition in accordance with OAC rule 5101:2-36-03 *PCSA Requirements for Intra-Familial Child Abuse and/or Neglect Assessment/Investigations*.

Table A:

Screened-In Report Date	Date Report Initiated	Initiation Type	Initiated in Accordance With OAC	Date of Face-to-Face Contact	Face-to-Face Contact Occurred in Accordance With OAC
[redacted]	[redacted]	Face-to-Face	Yes	[redacted]	Yes (Target Child) No (Sibling)
[redacted]		Face-to-Face *(A)	Yes	[redacted]	Yes (attempts within the first four working days) No (not in compliance for the five working day attempts, thereafter).
[redacted]	N/A	N/A	N/A	N/A	N/A

***(A) = Attempt**

Assessment of Risk and Safety

The case opened on [redacted] The caseworker initiated the report the same day by completing face-to-face contact with the target child and both parents at the hospital to informally assess risk and safety. There was no documentation in the activity logs regarding the caseworker's observations of the newborn; however, there was documentation that the caseworker discussed the [redacted] allegations with the parents. The [redacted] Outside of the maltreatment allegations,

there was no documentation that any other family circumstances were discussed or assessed during the caseworker's initial contact with the parents. [redacted]

[redacted]

Due to the target child being [redacted], the agency was mandated by OAC to follow the federal Comprehensive Addiction and Recovery Act of 2016 (CARA) requirements. The agency adhered to OAC 5101: 2-36-01(F)(1)(a)(i) *Intake and Screening Procedures for Child Abuse, Neglect, Dependency and Family in Need of Services Reports; and Information and/or Referral Intakes* regarding information entered into the intake report related to the target child's exposure to illegal substances. The agency also met the requirements outlined in OAC 5101:2-36-03 (S) *PCSA Requirements for Intra-Familial Child Abuse and/or Neglect Assessment/Investigations* in that the agency made an initial referral to [redacted] and had an initial plan for safe care for the target child to be placed in foster care. However, once the target child left foster care, the initial plan of safe care ended, and the agency did not ensure that there was a sufficient plan of safe care in place when the target child was [redacted] which was not aligned with requirements under OAC 5101:2-36-03 (S) *PCSA Requirements for Intra-Familial Child Abuse and/or Neglect Assessment/Investigations* to ensure the plan of safe care addressed the safety needs of the target child.

[redacted]

[redacted] There was no documentation in the case file that any other family circumstances were discussed or assessed during the caseworker's initial contact with the sibling.

[redacted] however, there was no documentation in the case file to confirm that the court granted the order of protective supervision. Furthermore, there was no documentation in the case file that the safety plan participants were notified of the discontinuation of the plan in accordance with OAC rule 5101:2-37-02 *PCSA Requirements for Completing the Safety Plan.*

The initial formal assessment of safety, utilizing the JFS 01401 *Comprehensive Assessment Planning Model Interim Solution (CAPMIS) Safety Assessment* tool, was entered in SACWIS on [redacted] which was timely in accordance with OAC rule 5101:2-37-01 *PCSA Requirements for Completing the Safety Assessment*. The quality of the Safety Assessment was inadequate. The information documented within the Safety Assessment was incident driven, lacked the assessment of safety threats outside of the [redacted] and did not include an assessment of past child welfare history, child vulnerability, and family protective capacities as required by OAC rule 5101:2-37-01. The Safety Assessment tool identified safety factor concerns [redacted] The Safety Assessment tool indicated [redacted]

The agency conducted a Family Team Meeting (FTM) at the agency on [redacted] during which the intake caseworker introduced the parents to the ongoing caseworker and to the foster mother. There was no documentation in the case file that discussions were held during the FTM between the caseworker, parents, and foster mother regarding the reunification plan for the target child, how the target child was doing while in the care of the foster mother, and/or visitation arrangements for the target child and parents. Interviews conducted in conjunction with the case file review confirmed that the FTM was a brief meeting in the lobby of the agency to introduce the parents to the ongoing caseworker and for the parents to meet the foster mother. Interviews revealed that after the FTM, the foster mother met with the parents alone to provide them

information regarding how the target child was doing while in foster care, along with providing the parents information on the child's care, daily schedule, and special needs. The manner in which the FTM was conducted in this case did not align with the agency's *Placement Team Meetings* policy, which states a meeting shall occur within 3-5 days of a child's placement, not exceeding 7 days after placement; that the caseworker(s), foster or kinship caregivers, birth parents and the child (if appropriate) shall meet to promote continuation of care that minimizes trauma to the child as a result of removal and to establish a healthy working relationship between the key adults in the child's life; that the Placement Team Meeting shall be conducted in the format that follows the Family-Centered, Neighborhood-Based Philosophy; and that the ongoing caseworker shall complete the documentation of the meeting using the agency's dictation format.

Following the FTM, the parents had an unsupervised visit with the target child at the agency. There was no documentation in the case file or information obtained through interviews whereby the reviewers could ascertain the parameters of the child/parent visit or the agency's decision to allow the parents to have an unsupervised visit with the target child, given the concern with [redacted] and the agency's ongoing assessment of the parents. Documentation in the case file and information gathered through interviews, reflect that the caseworker received information with concerns that [redacted] According to the agency's *Visitation for Child in Temporary Care* policy, "if at any time a parent appears to be under the influence of drugs and/or alcohol they are considered to be a safety risk to other families, children, and staff and they will be asked to leave the agency." There was no documentation in the case file or confirmation via interviews that the caseworker assessed the mother's alleged condition to determine if the mother was a safety risk to the target child during the unsupervised child/parent visit.

[redacted] There is no documentation to support that the agency completed further inquiry and/or assessed the reported concerns regarding the parents. The caseworker did not have contact with the family member who was identified as a possible source of information, in accordance with OAC rule 5101:2-36-03 *PCSA Requirements for Intra-Familial Child Abuse and/or Neglect Assessment/Investigations* (Q), which states the PCSA shall conduct and document face-to-face or telephone interviews with any persons identified as a possible source of information during the assessment/investigation to obtain relevant information regarding the safety of and risk to the child.

According to the case file documentation and confirmed through interviews, following the FTM and child/parent visit, a discussion was held between the agency director, supervisor, and caseworker which resulted in a decision being made to allow [redacted] This decision was based on agency practice, [redacted]

[redacted]

The initial formal assessment of risk, safety, and service needs, utilizing the JFS 01400 *CAPMIS Family Assessment* tool, was approved in SACWIS on [redacted], which was timely in accordance with OAC rule 5101:2-37-03 *PCSA Requirements for Completing the Family Assessment*. Although the Family Assessment was completed timely, the content within the assessment was incident driven, lacked a thorough assessment of safety threats and risk contributors of maltreatment outside of the [redacted] was not a comprehensive evaluation of the family and/or case circumstances, and did not include an assessment of child vulnerabilities or adult protective capacities. The Family Assessment minimally addressed [redacted] There were no documented discussions with the parents or sibling regarding [redacted] There were no documented conversations with the mother and father regarding their parenting techniques and no discussions with the parents about their perception of the family's strengths and problem areas. There were no visits to the family home to ensure that there were no environmental hazards and to ensure that the children's basic needs were met prior to completion of the Family Assessment. Although the family did not have prior involvement with children services in Ohio, there was no assessment of child welfare involvement elsewhere. Finally, prior to completion of the Family Assessment, the agency did not make collateral contact with the mother's service provider to confirm that she completed the [redacted]

Upon completion of the Family Assessment, the agency rendered a report disposition related to the reported maltreatment concerns. [redacted] however, there was no documentation within the activity logs or the Family Assessment to support the reason the agency [redacted]

[redacted]

[redacted] There was no documentation in the case file to support how the decision was made to [redacted] nor could that information be ascertained through interviews with agency staff. In addition, there was no assessment of the family home to ensure the home was safe and that the family had all the provisions necessary to meet the target child's basic needs.

Per the case review, there was inconsistent information documented related to determinations of the level of supervision needed during the mother's contact with the children. [redacted]

The frequency and quality of the caseworker's visits with the family were not sufficient to informally assess risk and safety on an ongoing basis. The caseworker visited with the family in the home on [redacted] Due to the circumstances of the case, with the target child [redacted] the frequency of visits was not sufficient to ensure the target child's safety. The activity logs had minimal documentation of the content of the home visits, and the documentation had similar verbiage from month to month; therefore, the quality of the visits could not be established. Furthermore, it was not clear through activity log documentation of the visits how the caseworker assessed and determined that the children's vulnerability for abuse or neglect was low.

[redacted]

[redacted] There was no documentation that the safety plan was implemented or monitored, in accordance with OAC rule 5101:2-37-02 *PCSA Requirements for Completing the Safety Plan.*

OAC rule 5101:2-38-09 *PCSA Requirements for Completing the Case Review*, requires that the agency complete the JFS 01413 *CAPMIS Case Review* to formally reassess risk and safety and the need for continued substitute care placement. The case review shall be completed no later than every 90 days from whichever of the following activities occurs first: the date the original court complaint was filed, the date of placement, the date of court-ordered protective supervision, or the date of the signatures on the case plan. In this case, the initial activity that occurred was the target child's placement in foster care on [redacted] and the Case Review was due by [redacted] but was not completed.

According to OAC rule 5101:2-42-87 *Termination of Substitute Care and Custody of a Child*, a child may be on leave from placement for a trial home visit for up to 60 consecutive days. The [redacted]

[redacted] The agency did submit the relative caregivers' fingerprints to the Bureau of Criminal Investigation (BCI) to request a criminal record check and did complete an alleged perpetrator search of abuse and neglect history through SACWIS, in accordance with OAC rule 5101:2-42-18 *PCSA and PCPA Approval of Placements with Relative and Nonrelative Substitute Caregivers.* However, the agency did not assess the safety of the relatives' home and did not complete the JFS 01447 *Assessment of Relative or Nonrelative Substitute Caregiver* home assessment required by OAC rule 5101:2-42-18.

[redacted] The caseworker continued attempting to contact the parents by phone and continued attempting to make face-to-face contact with the target child and the parents. Between [redacted] the agency made seven attempted phone contacts and fourteen attempted face-to-face contacts.

OAC rule 5101:2-36-14 *Protective Service Alert* requires that an agency issue a Protective Services Alert (PSA) in SACWIS when the whereabouts of a child or his parents are unknown, and the agency has reason to believe the child is in immediate danger of serious harm. The agency did not enter a PSA in SACWIS. The agency contacted law enforcement to request assistance in locating the target child on [redacted] but there was no documentation in the case file that law enforcement entered information into the National Crime Information Center (NCIC) database. The agency did contact the National Center for Missing and Exploited Children (NCMEC) on [redacted] due to the agency not being able to locate the target child.

During the period under review, a subsequent maltreatment report was received with concerns for the target child. [redacted] report was initiated, and the initial attempt at face-to-face contact occurred within the state mandated time frames. When the caseworker was not successful in making face-to-face contact with the family within the required time frames, requests were submitted timely to extend the completion of the Safety Assessment, Family Assessment, and Report Disposition in accordance with OAC rule 5101:2-36-11 *Extending Time Frames for Completion or Waiving Completion of Assessment/ Investigation Activities.*

On June 6, 2019, both parents were arrested for outstanding warrants. The agency became aware via media on June 12, 2019 that the target child was found deceased in a well after the father led law enforcement to the child's body. [redacted] Per OAC rule 5101:2-36-01 *Intake and Screening Procedures for Child Abuse, Neglect, Dependency and Family in Need of Services Reports; and Information and/or Referral Intakes*, all information alleging suspected child abuse shall be recorded in SACWIS no later than the next business day; however, the child fatality report was not entered in SACWIS until June 21, 2019. Timeliness of initiation and face-to-face contact with the target child were not applicable due to the target child's fatality. There was no documentation in the case file that the mother and father were advised of the allegations against them, in accordance with OAC rule 5101:2-36-03. Face-

to-face contact with the parents did not occur in accordance with OAC rule due to the parents' incarceration and criminal investigation related to the target child's fatality.

Technical Assistance

The agency is provided the following technical assistance related to casework practice and OAC compliance.

SCCS needs to enter all information regarding suspected abuse or neglect in SACWIS no later than the next business day, in accordance with OAC rule 5101:2-36-01 *Intake and Screening Procedures for Child Abuse, Neglect, Dependency and Family in Need of Services Reports; and Information and/or Referral Intakes.*

SCCS is encouraged to conduct interviews with anyone identified as a possible source of information, in accordance with OAC rule 5101:2-36-03 *PCSA Requirements for Intra-Familial Child Abuse and/or Neglect Assessment/Investigations.*

SCCS is reminded to document the assessment of safety threats, past child welfare history, child vulnerability, and family protective capacities within the Safety Assessment, in accordance with OAC rule 5101:2-37-01 *PCSA Requirements for Completing the Safety Assessment.*

SCCS needs to ensure that the parents and responsible parties are notified in writing within two days of the discontinuation of a safety plan, in accordance with OAC rule 5101:2-37-02 *PCSA Requirements for Completing the Safety Plan.*

SCCS is cautioned that case decisions should be individualized based on a holistic assessment of the family's circumstances. Case decisions should be based on the totality of the assessment, rather than an over-reliance on any one piece of information, such as a negative drug screen.

SCCS needs to ensure that caseworkers take additional time to visit the family, even if it requires multiple home visits, during the assessment or investigation to gather pertinent information and complete a comprehensive assessment of the family's circumstances.

SCCS caseworkers need to routinely question families regarding child welfare history in other states, particularly since Scioto County borders another state.

SCCS is advised to complete Case Reviews no later than every 90 days from the date the initial activity occurred, in accordance with OAC rule 5101:2-38-09 *PCSA Requirements for Completing the Case Review.*

SCCS is reminded that prior to placing a child with a relative substitute caregiver they are required to assess the safety of the home and complete the JFS 01447, in accordance with OAC rule 5101:2-42-18 *PCSA and PCPA Approval of Placements with Relative and Nonrelative Substitute Caregivers.*

SCCS is reminded that trial home visits may not exceed 60 consecutive days, in accordance with OAC rule 5101:2-42-87 *Termination of Substitute Care and Custody of a Child.*

II. PERMANENCY

Children have permanency and stability in their living arrangements

The target child had one placement setting in a non-relative family foster home, and the sibling had one placement setting in a relative kinship home. The placements for both children were stable and in the best interest of the children.

The initial case plan, signed by the parents on [redacted] established the permanency goals of [redacted] for the target child and [redacted] for the sibling. The initial permanency goals were established timely. At the time the case plan was signed, the target child was [redacted] therefore, the permanency goal of [redacted] was no longer appropriate at that time. Furthermore, the court was not advised of the target child's change in living arrangement prior to that change being enacted by the agency. The case plan was not amended to document a change in the legal status of the sibling or to modify the sibling's permanency goal and document the sibling's placement when [redacted] which is required within seven days of a change, in accordance with OAC rule 5101:2-38-05 *PCSA Case Plan for Children in Custody or Under Protective Supervision.* The permanency goal of [redacted] was no longer appropriate for the sibling after the sibling was [redacted]

Continuity of family relationships and connections

The agency did make efforts to preserve the children's important connections with immediate and extended family. [redacted] however, there was no documentation in the case file regarding how the location, duration,

frequency, and supervision of visits was determined, as required by OAC rule 5101:2-42-92 *Visitation for Child in Temporary Custody.*

Technical Assistance

The agency is provided the following technical assistance related to OAC compliance.

SCCS is reminded to amend the case plan within seven days of a change in a child's legal status, permanency goal, or placement, in accordance with OAC rule 5101:2-38-05 *PCSA Case Plan for Children in Custody or Under Protective Supervision.*

SCCS is advised to document how the location, duration, frequency, and supervision of visits was determined, in accordance with OAC rule 5101:2-42-92 *Visitation for Child in Temporary Custody.*

III. WELL-BEING

Needs Assessment for Services

At the onset of the case and throughout the life of the case, the agency did not complete a comprehensive assessment of the children's needs. After the target child's birth, it was reported

[redacted]

and how to properly care for the target child. In addition, the agency did not visit the parents' home prior to the target child returning to the home to ensure that the parents had the necessary supplies to meet the target child's basic needs. The agency did refer the target child to

[redacted]

Regarding the sibling, there were no documented discussions with the parents or with the sibling regarding the agency's assessment of the sibling's needs. After the sibling was placed in

[redacted]

The agency did not complete an informal or formal comprehensive assessment of the parents'

needs. The agency did assess the reported concerns of the [redacted] but did not assess for any other needs. The agency referred the [redacted] and [redacted] There were no documented assessments or discussions regarding the father's needs, despite reports of the [redacted]

Case Planning

The agency did involve the mother and father in the case planning process, but the agency did not involve the sibling, who was age and developmentally appropriate for involvement in the case planning process. During the parents' involvement with their case, both prior to and after the target child [redacted] the parents provided their opinions on what direction they would like the case to take, including their request that [redacted] Per the case plan document, letters were sent to the parents, their attorneys, and the guardian ad litem (GAL) to invite them to participate in a case planning meeting. However, there is no documentation within the case file that the case planning meeting occurred.

Caseworker Visits

The frequency and quality of the caseworker's visits with children and the parents was not sufficient to ensure the children's safety and well-being or to promote achievement of case plan goals. OAC rule 5101:2-38-05 *PCSA Case Plan for Children in Custody or Under Protective Supervision* requires monthly face-to-face contact with all children on the case plan; however, there were no contacts with the sibling during March 2019. Although the caseworker visited with the target child and the parents in the home on [redacted] in accordance with rule, monthly visits were not sufficient based on the target child's age and vulnerability and the case circumstance of the target child [redacted] The activity logs lacked documentation of the caseworker's observations of the children and conversations with all family members during face-to-face contacts. In addition, the activity logs had similar verbiage from month to month; therefore, the quality of the caseworker's visits with the family could not be established related to services, case plan goals, and the safety, permanency, and well-being of the children.

Technical Assistance

The agency is provided the following technical assistance related to OAC compliance.

SCCS needs to ensure that caseworkers complete face-to-face contacts with all children on the case plan no less than monthly, in accordance with OAC rule 5101:2-38-05 *PCSA Case Plan for Children in Custody or Under Protective Supervision.* SCCS should consider more frequent visitation based on individualized case circumstances.

SYSTEMIC FINDINGS

Per the case review, the following systemic issues were identified:

- There were concerns identified related to quality of the agency's documentation, including documentation of the agency's assessment of risk and safety and documentation of the agency's structured decision making.
- The CAPMIS tools are intended to document and determine the assessment of risk and safety of the children throughout the life of a case and to guide decision making at critical intervals while the agency is involved with the family. The initial formal assessments of risk and safety within the CAPMIS Safety Assessment and Family Assessment were not comprehensive in assessing safety, risk, and/or services, and contained minimal information related to the circumstances of the case.
- There were no Case Reviews completed to document the ongoing formal assessment of risk and safety.
- The quality of informal assessments of risk and safety during face-to-face contacts with the family could not be ascertained through documentation within the activity logs.
- The agency's decision-making process, including the decision for the target child's reunification to occur, was not captured in the CAPMIS tools or elsewhere in the case file.

SUMMARY & RECOMMENDATIONS

The administrative review of the [redacted] fatality concluded on August 30, 2019. The review identified areas for improvement in casework practice and OAC rule compliance. The primary concerns identified were the agency's decision making, inadequate documentation within the case file, and a lack of comprehensive and quality assessments of risk and safety.

Although the agency completed the initial formal assessments of risk and safety in a timely manner, utilizing the Safety Assessment and Family Assessment tools, the assessments were incident driven and were not comprehensive in scope related to the circumstances of the case. The agency assessed the reported concerns of the [redacted] but did not complete a comprehensive assessment of the family's circumstances, including safety threats, past child

welfare history, child vulnerability, and family protective capacities.

The CAPMIS tools set up a decision-making process that begins with the Safety Assessment that determines the immediate safety of the children. Once safety is established, the Family Assessment allows for a more thorough evaluation of the family's strengths and needs. Once strengths and needs are determined, then the agency and family have 30 days to develop the case plan based on the Family Assessment that will build on their strengths and address their needs. In this case, [redacted] All relevant information was not gathered and thoroughly assessed prior to making a permanency decision.

The informal assessments of risk and safety during face-to-face contacts with the family were not of sufficient frequency or quality to assess the family's circumstances or to ensure child safety. Due to the intensive risk and vulnerability of the target child, more frequent visitation in the home was warranted. The activity logs lacked documentation of the caseworker's observations of the children and conversations with all family members during face-to-face contacts. When safety threats were identified, the agency did not implement an appropriate safety plan to control the active safety threats and did not continually monitor the safety plan. Finally, the case file lacked documentation to support the caseworker's critical thinking and the agency's structured decision-making process.

Based upon the findings of this review, The Ohio Department of Job and Family Services has the following recommendations for Scioto County Children Services:

1. SCCS should visit the family's home during the assessment or investigation to assess the safety of the home environment and to determine if the children's basic needs are met.
2. SCCS should conduct interviews with all household members and thoroughly document all information as it pertains to not only the allegations of child maltreatment, but also all safety and risk concerns, family's strengths and needs, the child vulnerabilities, and the parents' protective capacities.
3. SCCS should conduct and document interviews with any person identified as a possible source of information during the assessment or investigation to obtain relevant information regarding the safety and risk to the child in accordance with OAC 5101:2-36-03 *PCSA Requirements for Intra-Familial Child Abuse and/or Neglect Assessment/Investigations.*
4. SCCS should make case decisions based on a holistic and individualized assessment of the family's circumstances and assure that the decision-making factors are documented in the case file.

5. SCCS should amend the case plan within seven days of a change in a child's legal status, permanency goal, placement, or visitation plan, or when a party must be added to or deleted from the case plan in accordance with OAC 5101:2-38-05 *PCSA Case Plan for Children in Custody or Under Protective Supervision.*
6. SCCS needs to ensure that casework staff adhere to the agency's *Placement Team Meetings* and *Visitation for Child in Temporary Care* policies when handling cases where children are placed in the agency's custody and substitute care placement. In review of the case, it was apparent that casework staff were not following these policies.
7. SCCS should document how the location, duration, frequency, and supervision of parent/child visits was determined in accordance with OAC 5101:2-42-92 *Visitation for Child in Temporary Custody.*
8. SCCS should complete the JFS 01447 *Assessment of Relative or Nonrelative Substitute Caregiver* to document home assessments for prospective substitute caregivers in accordance with 5101:2-42-18 *PCSA and PCPA Approval of Placements with Relative and Nonrelative Substitute Caregivers*
9. All child welfare staff, consisting of the agency administrator, supervisors and caseworkers, should attend the following CAPMIS training modules: Assessing Safety, Safety Planning, Strengths and Needs, and Case Planning.
10. All child welfare staff should participate in training related to parents with substance abuse and related to children exposed and/or affected by parental substance abuse.

The Ohio Department of Job and Family Services will require Scioto County Children Services to develop a Corrective Action Plan to address the following areas of non-compliance:

1. SCCS shall ensure caseworkers utilize CAPMIS tools, including Safety Assessments, Family Assessments, Case Reviews, Semiannual Administrative Reviews, and Reunification Assessments, to document comprehensive formal assessments of the family's circumstances, including safety threats, past child welfare history, child vulnerability, and family protective capacities. SCCS shall also utilize these tools to guide casework staff with critical thinking and structured decision making when working with families.
2. SCCS shall complete face-to-face visits with parents and all children in the home with enough frequency to ensure child safety, based on individual case circumstances.
3. SCCS shall enter detailed activity logs and shall thoroughly document informal assessments of risk, safety, and service needs during face-to-face contacts, and shall include the caseworkers' observations of the children and conversations with all family members during face-to-face contacts pursuant in accordance with OAC 5101:2-33-23 *Case Records for Children Services.*
4. SCCS shall develop safety plans to immediately control active safety threats and shall not discontinue safety plans until the threat of serious harm no longer exists in accordance with

OAC 5101:2-37-02 *PCSA Requirements for Completing the Safety Plan.*

The agency's Corrective Action Plan will be due 30 days from issuance of this report. ODJFS will be available, upon request, to assist and provide support to the agency in the development and implementation of the Corrective Action Plan.

Respectfully submitted by:

Lynn Boose
Technical Assistance Specialist
ODJFS, OFC, BSPA, CPOE Section

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Scioto County
Children Services

Cherishing Children Strengthening Families

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September 27, 2019

Ohio Department of Job and Family Services

Office of Families and Children

RE: Response to Child Fatality Administrative Review

Dear Lynn,

I regret that I am having to respond to a child fatality review report as this means that a child in our care had died. Please know that everyone at Scioto County Children Services has been tremendously impacted by the loss of this child and we hope to put practices and policies in place that will attempt to prevent such fatalities in the future. However, because of the information contained in this report and the impact it will have on the agency and the children and families we serve in this county, I am compelled to be honest in my rebuttal to the report as evidenced from the remainder of this analysis of your report.

Thank you for taking the time to review our child fatality case and providing us with a thorough overview of your findings. While I appreciate you getting your findings to our agency in a timely manner, I am concerned that the Ohio Department of Job and Family Services (ODJFS) only allowed my staff and me one hour to review the 20-page document before meeting with your team that included ODJFS Deputy Director Carla Carpenter. It is my understanding that my peers have been given upwards of 20 days to review their findings before sitting in an exit conference with only their technical assistance specialist present. I hope it was not the intent of ODJFS to only allow us limited time for our review to hinder our ability to respond to the opinions in the exit report. Because we did not have the opportunity to thoroughly review our report and prepare our rebuttal at the exist conference I will use this platform to do so.

You continually referenced [redacted] of the child in the draft report; however, the hospital where the child was delivered does not test [redacted] and the report should state the [redacted] So, I am unclear why you would continuously state [redacted] when clearly this is not what the dictation nor the results from the hospital would have indicated. It appears as if your own investigative

techniques failed to lead you to find the accurate information that was presented to you in case dictation in SACWIS and contents of the hard case file. You have pointed out multiple times throughout this report regarding lack of accurate documentation and poor investigatory skills on the part of my staff yet you yourself have failed to present the accurate facts of the case.

It is my assertion that if it is that easy for you to make that type of mistake reviewing or working one (1) case imagine how difficult it is for caseworkers, who carry caseloads four times the recommended state average (40-50 cases per worker), to make a mistake in documentation or not have enough time to ensure that every piece of dictation accurately reflects every encounter they have with the children and families they work with on a daily basis.

It is also my understanding that multiple people at the state level reviewed or provided input into this report prior to it being released to my agency, yet no one found the mistake. Is it that the people who supervise you, trusted your ability to collect accurate data and document it accordingly, therefore they did not pore over the actual case documentation themselves and therefore the inaccurate information was kept in the draft report and believed to be true and factual? I would argue that this is very similar to the structure at our agency as well. We (as the management team) trust that investigators and caseworkers that are trained to do their jobs can enter the data appropriately and present the information accurately and then supervisory decisions are made based on the caseworker's report of the field casework.

No matter how many predictive analytics you employ no one, and I mean no one on this Earth, can predict that a mother or father is going to engage in potentially murderous behavior. You can abide by every policy, employ every rule and implement every safeguard and you still cannot predict nor control human behavior. It appears throughout this report it is the opinion of ODJFS that we somehow could have prevented this child's fatality if we had better dictation or were in the home more often. Yet at the end of the day lack of detailed information and lack of trips to the home was not the reason the child died. It is my understanding, based on the current charges against the parents, that murder may be the cause for the child's death. (As of the date of this writing we still do not even know the actual cause of death for the child in question.)

Unfortunately, as a child welfare agency, we do not have access to systems like law enforcement or even the staff at our county JFS. We cannot readily determine a person's criminal past, nor can we even determine their current address in the state benefits system or if they have received benefits from ODJFS. We rely heavily on information that can be obtained via an internet search or from the parents and children we interview. ODJFS wants us to use past behaviors to predict future behaviors yet we cannot even readily determine if a person has an active warrant, their last known address or if they have been sanctioned from receiving state benefits from Ohio or any other state. Ready access to these or similar databases would be beneficial for child welfare investigators.

It appears we are being faulted for allowing a father his parental right to parent his child. We are criticized for allowing a father who was successfully rearing his older child (who did well in school and denied any knowledge of drug use in the home), had never had a child abuse report in Ohio, had no violent criminal history and tested negative for drugs on several occasions to parent

his newborn son. All these factors equated to a low-risk score on the assessment required by ODJFS. It stands to reason that based on the definition by ODJFS that high risk families have significantly higher rates than low risk families of subsequent child abuse and/or neglect report and substantiation and are more often involved in serious abuse or neglect incidents; therefore one can infer low risk families have a lower risk of subsequent child abuse and substantiations and are less likely to be involved in serious abuse or neglect incidents. Once again, I reiterate that it would have been impossible for us to predict the outcome of death for our child that was placed with his father.

There is also reference to the "fact" that the mother [redacted] came to the family team meeting at our agency on [redacted] However, it is noted in the case file that two caseworkers were present and met with both the parents and neither of them suspected that [redacted] However, it is documented that the next day, [redacted] We are also faulted for not following our own policy regarding allowing the parents to visit. Our policy clearly states if at any time a parent appears to be under the influence of drugs and or alcohol they are a safety risk to other families, children and staff and they will be asked to leave the agency. At no time during the visit did anyone suspect or report a suspicion that [redacted] was under the influence which included two caseworkers, the front office staff person, and the foster mother. Once again only after the family visited with the child, the next day [redacted] So therefore, I contend that our policy was followed as no one at the time of visit reported observations of [redacted] to be under the influence or pose a safety risk. Furthermore, the family was in room adjacent to our lobby with a camera that projects to a monitor at our front desk.

[redacted]

I would also like to note that you cited us for not investigating the information received by the [redacted] via social media that reported both parents had a drug history. However, this information was not received during the investigatory phase as the case was already transferred to the ongoing department. While I agree this information should have been explored I disagree that it should have been cited in the investigatory phase as the investigator had already transferred the case to the ongoing department. Also, I think it is important to note that it is rather interesting that a [redacted] would have been sought out via social media to be told about a child [redacted] considering the children [redacted] should be confidential. Likewise, it would have been beneficial if [redacted] would have encouraged the person to report this information directly to the agency. We will ensure that [redacted] are

reminded to either ask the person with the information to report to us directly or ask them to share the person's contact information with the agency, so we can discuss the concerns directly with the referent.

I also want to clarify that as the agency director I was not directly involved in the initial decision making of [redacted] Your documentation erroneously states that after the team meeting there was a meeting held between the agency director, supervisor, and caseworker which resulted in the decision to [redacted] Case documentation notes that the meeting occurred between the caseworker and the supervisor. As the director, I was made aware of the decision after the supervisor spoke with [redacted] and based on the information verbally presented I did not disagree with the decision.

Also, you indicate on page 10 of your report that there was no documentation in the case file or information obtained in interviews with staff to support how the decision was made to [redacted] However, earlier in the report on pages 8-9 you state that the "decision was based on agency practice, because the father had provided two negative drug screens, was reported to have employment, had no prior CPS history in Ohio, and no violent or drug related criminal history." So, it is unclear to me how you were able to ascertain this information if it was not derived from case documentation or interviews. Ultimately, the information (which can be accessed in SACWIS) was contained in the case record and documented in the activity log dated [redacted] Therefore, once again I am unsure if it is poor investigatory skills or simply the lack of detailed documentation that led you to contradict yourself in this review. As noted previously, it is easy to make errors and mistakes when overwhelmed with casework.

It is also noted that the frequency of the visits was not sufficient to ensure the target child's safety. OAC rule 5101:2-42-65 states that we are required to visit the target child monthly which we did. One month we even made two successful visits to home. We would love to be able to see our children in care more often but due to the high volume of cases we have and the limited number of caseworkers we unfortunately, only can adhere to Ohio rule and do not have the time to go beyond rule requirements. At the time of the death of this child Ohio's child welfare system was significantly underfunded and our agency had over 200 children in custody. Our caseworkers were carrying caseloads that consisted of 30-50 cases per worker. The state recommended average is 10-15 cases per worker. In Scioto County, we were hit hard by the opiate epidemic and it took a tremendous toll on the children and families we serve as well as our staff, yet we did not see an increase in our state child protection allocation nor did we receive any funding from our county commissioners to help offset the burden on our system. We are now hopeful that with the increase in our state child protection allocation we can add more casework staff and be able to have manageable caseloads. If this is the case, we will be able to do more than the state mandated monthly visits to the homes of our children in care.

In conclusion, I am not contesting the fact that our dictation was lacking, that our assessments were not thorough, or that we should develop safety plans to immediately control active safety threats. What I am contesting is there was information presented in this report as factual when indeed it was not. I am also contending that anyone can become overwhelmed with case

documentation and be unable to report every detail of a case with 100% accuracy as I believed was evidenced in this report. Ultimately, I am contending that staff caseload size played a major part in the lack of thorough dictations and case dictation being entered timely. This agency has been under a significant amount of stress over the last four years due to the opiate epidemic, the constant turnover of staff and the lack of resources both financially and in sheer workforce size.

Finally, having a child die that is in the care of a child welfare agency is unacceptable and everyone at our agency is well aware of this fact. All our lives are forever changed as being a part of this tragedy. Please know we will strive to be better protectors of the children entrusted to our care, but we will need the help of the state and local governments to do so. We need more financial support from both entities to have more caseworkers trained and in the field. We hope by doing so we can reduce the number of children that are abused and neglected and ultimately eradicate child fatalities due to abuse and neglect in our county.

Respectfully submitted,

Lorra S. Fuller, PsyD

Executive Director